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ACUTE LACUNAR ADENOIDITIS.

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Acute lacunar adenoiditis is pathologically similar to acute follicular tonsillitis with which it is frequently associated.

Because of this association and the fact that the tonsillar affection is more widely known and more readily diagnosed, the adenoiditis may frequently be overlooked entirely and run its course undiagnosed and untreated, with the possibility of recurrences and sequelæ.

Ordinarily, having diagnosed the tonsillitis, one is not likely to examine the nasopharynx. In fact, with tonsils and pillars acutely inflamed and swollen, it is not an easy matter to do a posterior rhinoscopy on account of the narrowing of the fauces and their heightened irritability. The presence of numerous yellow or white capped enlarged lymphatic follicles on the posterior wall of the oropharynx as well as along the nasopharyngeal fold should always excite suspicion of the process higher up and lead one to pursue the examination further.

Less frequently the adenoids may become acutely inflamed without involving the tonsils at all, or the process may occur in patients whose tonsils are out. These cases should present no difficulties in diagnosis, despite the apparently normal appearing fauces and oropharynx. All that is necessary is that one take the trouble to use the mirror or else examine the nasopharynx by anterior rhinoscopy, as will be described later.

Two cases in point will be briefly cited:

Miss K. T., aged 23 years, had her tonsils removed in June, 1917. For some time after, she complained of aching in the ears and received treatment, but with no permanent relief. A few days before appearing in our clinic she had a chill and a rise in temperature with severe pain in both ears and in the throat. The examination disclosed the following: Both membrana tympani were normal except for a slight retraction and a bit more translucency than normal. Nothing was found in the

nose but a moderate swelling of the turbinates. After the application of adrenalin, the posterior nares could be made out and were seen to be full of a thick mucopurulent secretion.

The tonsils were absent, but the pillars were intact and not the least inflamed. The oropharynx was also normal. On inspection with the mirror the nasopharynx was found to be filled with a large mass of adenoids, which were markedly inflamed and covered with a thick, tenacious mucopurulent secretion. A partial cleansing revealed the depressions in the adenoid mass oozing the same type of secretion. Cultures later showed the predominant organism to be the streptococcus. The posterior cervical glands on both sides were enlarged and tender.

The temperature during the attack varied from 100 to 102.6 degrees F.

Under local cleansing treatment plus applications of argyrol, the condition cleared up and, despite our insistence, the patient elected not to have the mass removed, although it was easily the size of a hickory nut.

Case 2.—Miss N. R., aged 18 years, came in as a suspected acute mastoid. She gave a history of severe pain in the region of the tips of both mastoids radiating into the neck, elevation of temperature, general malaise and muscular soreness, and pain in moving the mandible. There was tenderness and enlargement of the posterior cervical glands on both sides. The external auditory canals and drum membranes were found to be absolutely normal. The tonsils were slightly enlarged and moderately reddened. The adenoids, on inspection with the mirror, were found to be large and lobulated and covered with an exudate which could be seen extending deeply into the recesses of the mass. This case also recovered within a few days.

The symptoms as described in these cases are substantially as found in various textbooks. There seems, however, to be some slight differences in the nomenclature of the disease.

Gottstein and Kaiser[1] describe it as acute follicular or lacunar adenoiditis and draw a distinction between it and simple catarrhal inflammation of the adenoid. They further mention a more severe type as "acute phlegmonous inflammation of the adenoid," in which there is an abscess formation that may

rupture spontaneously or may burrow downward, presenting in the oropharynx as a retropharyngeal abscess.

Zarniko[2] considers three types of acute inflammation of the adenoids, the catarrhal, lacunar and follicular, although the distinction between the two latter is not made very clear. He mentions acute rhinitis, otitis media, epipharyngeal abscess and metastic infections as complications likely to ensue.

Kyle[3] describes it only as "acute nasopharyngitis," considering the inflammation as of all the tissues of the nasopharynx rather than the adenoids alone.

Grünwald[4] in his Atlas gives a very good picture of the disease, which he calls "acute lacunar inflammation of the pharyngeal tonsils."

Ballenger[5] presents a clear description of the disease and calls attention to reddening of the lateral pharyngeal folds, which are frequently studded with yellowish spots, indicating infection of the numerous lymphatic follicles in the oropharynx.

The etiologic factors as a rule are exposure to inclement weather, a general state of depressed vitality and infection with streptococcus.

Bryant[6] reports ten cases of streptococcic infection of the adenoids which were all cured by local treatment.

A consideration of the cases cited above brings forcibly to mind not alone the necessity of thoroughly examining the nasopharynx in every instance where earache is a symptom, but also the important fact that many adults possess large masses of adenoid tissue which have failed to undergo the regressive changes generally assumed to have taken place with puberty. It is surprising, if one will take the trouble to look, how many adults harbor appreciable masses of these vegetations. Practically no age is exempt.

Logan[7] reports that out of a series of 652 adenoidectomies 284, or about 40 per cent, were on patients between the ages of 25 and 59. He further cites another case in a patient of 64 years.

Cuvillier[8] saw two cases at the ages of 60 and 65 years. Solis Cohen[9] had one in a man of 70 years. Schaeffer[10] reports one at the age of 71 years, and Couetoux[11] another at 72 years.

Lewis[12] further quotes several more recent observers along the same lines.

It is important that this knowledge be given wide circulation, not so much on account of the acute attacks of adenoiditis (which are usually self limited and of no great severity), but because of their recurrence and the numerous more serious consequences which may follow in their wake. Current medical literature is full of references to the adenoids as the cause of nasal obstruction, middle ear affections, chronic laryngitis, and so far as laryngologists are concerned the subject is a closed book.

The general practitioner, however, I find, is somewhat lacking in knowledge of these facts, particularly with reference to adult patients. The principal reasons for this are the usual acceptance as dogmatic of the dictum that adenoids disappear with maturity, and the lack of skill in making examinations of the nasopharynx.

Physicians as a rule make their diagnosis of adenoids by palpating with the index finger in the nasopharynx, which, to my notion, is an unnecessarily painful and disagreeable procedure. It has been my custom, in teaching students, to demonstrate to them that when by reason of lack of practice on the part of the examiner or an unruly pharynx the posterior rhinoscopy cannot be successfully performed, the adenoids can clearly be made out by anterior rhinoscopy if the inferior turbinates have previously been well shrunk with adrenalin. Unless the turbinates are excessively hyperplastic or a very markedly thickened, deviated septum is present, the procedure can always be carried out. All that is necessary is that adrenalin be liberally applied the whole length of the turbinate and that the light be properly focused. By holding the patient's head bent a little forward of the erect position and directing the light along the floor of the nose or between the turbinal and the septum, and by coming a little closer to the patient than for the ordinary anterior rhinoscopy (bearing in mind that the focal distance of the mirror is a fixed point), the examiner is enabled to illuminate the posterior nares and roof of the nasopharynx. Of course, with the Kirstern light the problem of focusing is simplified. If the adenoids are very large and irregular, they can at once be made out by their very irregu-

larity of contour, their pendulous position and the numerous lights and shadows produced by the examining light playing over the surface. If the mass be smooth, as frequently it is in adults, it can be outlined by having the patient say "k" or "cocoa," which brings the soft palate upward against the mass and alters its position. It will be noted at the same time that the reflected light moves with the mass. Where the adenoids are very large they may be seen to reach down to the level of the inferior border of the lower turbinal, and adenoids of any appreciable size nearly always stop the soft palate from reaching its proper height during contraction, as compared with normal.

This method, while difficult at first, can nevertheless be perfected with practice, and is particularly recommended for examining children, as well as adults.

A painful and disagreeable procedure, such as palpation of the nasopharynx, should be avoided because it leaves a horrible impression on the minds of the little ones which will alienate them from physicians in general and make future examinations difficult.

To conclude:

1. Adenoids in appreciable masses are of frequent occurrence in adults.

2. Acute lacunar adenoiditis should be thought of in cases of earache with fever where the ears are normal, regardless of whether the tonsils are absent or present, inflamed or not.

3. Diagnosis of adenoids should always be attempted by anterior rhinoscopy in preference to palpation in cases where posterior rhinoscopy cannot be carried out.

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